Suicide Prevention

A Few Facts...

- More people die from suicide than from homicide.
- There have been more suicides than homicides each year since 1950.
- In 1997, 30,535 Americans took their own lives.
- In 1997, suicide was the eighth leading cause of death in this country. It was fourth among 25-44 year olds.

Who Commits Suicide?

- While anyone, at any age can complete suicide, recent studies reveal that suicides in the US Army follow a bi-modal pattern.
- The first increase is in the 20-29 age group
- These tend to be impulsive acts stemming from substance abuse, relationship and financial problems, and UCMJ actions.

- The second group is the 40-49 category. These suicides often stem from relationship failures, substance abuse, and mood disorders.
- For current data on suicides in the Army, see

  http://www.odcsper.army.mil/default.asp?pageid=66f.

Myths & Facts

MYTH: Most suicides occurs with little or no warning.

RATIONALIZATION: If you can't see suicide coming, there's nothing anybody can do.

FACT: Most people communicate warning signs of how they are reacting to or feeling about the events that are drawing them toward suicide. These warning signs, or invitations for others to offer help, come in the form of direct statements, physical signs, emotional reactions, or behavioral cues. They telegraph the possibility that suicide might be considered as a means to escape pain, relieve tension, maintain control, or cope with a loss.

Facts and Myths

- **MYTH**: You shouldn't talk about suicide with someone who you think might be at risk because you may give that person the idea.
- **RATIONLIZATION**: It's best just to avoid it altogether.
- **FACT**: Talking about suicide does not create or increase risk. It reduces the risk. The best way to identify the intention of suicide is to ask directly. Open talk and genuine concern about someone's thoughts of suicide is a source of relief and often one of the key elements in preventing the immediate danger of suicide.

Facts and Myths

- **MYTH**: People who talk about suicide don't do it.
- **RATIONALIZATION**: There is no need to get involved with people who talk about suicide.
- **FACT**: People who attempt suicide usually talk about their intentions, directly or indirectly, before they act. Four out of five people who commit suicide talk about it in some way with another person before they die. Failing to take this talk seriously is suspected of being a contributing cause in many deaths by suicide.

Facts and Myths

- **MYTH**: Non-fatal acts are only attention-getting behaviors.
- **RATIONALIZATION**: These behaviors can either be ignored or punished.
- **FACT**: For some people, suicidal behaviors or "gestures" are serious invitations to others to help them live. If help is not forthcoming, there is an all too easy transition between a desperate invitation to receive help and a conclusion that help will never come—between little or no intent to die and a higher intent to die. Help, not punishment, is effective.

Facts and Myths

- MYTH: A suicidal person clearly wants to die.
- RATIONALIZATION: There's no point in helping. They will just keep trying until they have completed suicide.
- FACT: Most suicidal people are ambivalent about their intentions right up to the point of dying. Very few are absolutely determined or completely decided about ending their life. Most people are open to a helpful intervention, sometimes even a forced one. The vast majority of those who are suicidal at some time in their life find a way to continue living.

Facts and Myths

- **MYTH**: Once a person attempts suicide, he/she won't do it again.
- **RATIONALIZATION**: I don't need to be concerned now; the attempt will be cure enough.
- **FACT**: Although it is true that most people who attempt do not go on to kill themselves, many do attempt again. The rate of suicide for those who have attempted before is 50 times higher than that of the general population: 50% of completers have attempted before.

Facts and Myths

- MYTH: A suicidal person's need is so great that I can't possibly make a difference.
- RATIONALIZATION: They need more than I can provide, so only a specialist can help.
- FACT: There are as many reasons for suicidal behaviors as there are people who engage in them. All that is required is paying attention to what the person is saying, taking it seriously, offering support, and getting help. Many persons are lost to suicide because this type of emergency first aid and immediate support wasn't offered or available.

Facts and Myths

- MYTH: If a person has been depressed and suddenly seems to feel better, the danger of suicide is over.
- RATIONALIZATION: They're better. I won't have to talk to them about suicide or keep my eye on them.
- FACT: The outcome of feeling better can go two ways: 1) full recovery as one would hope, 2) Increased risk because the emotional conflict over living or dying has been resolved in favor of death. Open and direct discussion is the only way to determine which of these directions applies.

Stressful situations that can trigger suicidal feelings

- A bad evaluation for an enlisted soldier or officer.
- The break up of a close relationship.
- Drug or alcohol abuse.
- Renewal of bonding with family on return from long field training or isolated tour.
- Leaving old friends.
- Being alone with concerns about self and family.

- Financial stressors.
- New military assignments.
- Recent interpersonal losses.
- Loss of self-esteem/status.
- Humiliation.
- Rejection (e.g. job, promotion, boy/girlfriend)
- Disciplinary or legal difficulty.
- Exposure to suicide of friend or family member.

- Discharge from treatment or from service.
- Retirement.

Depression and Hopelessness

Hopelessness:

- Believing all resources to be exhausted.
- Feeling that no one cares.
- Believing the world would be better off without you.
- Total loss of control over self and others.
- Believing death to be the only way out of the pain.

Depression:

- Difficulty concentrating or remembering.
- Loss of interest in or enjoyment of usually pleasurable activities.
- Loss of energy, chronic fatigue, slow speech and muscle movement.
- Decreased effectiveness or productivity.
- Feelings of inadequacy or worthlessness, loss of self-esteem.

Depression (Cont'd)

- Change in sleep habits – inability to sleep or want to sleep all the time.
- Pessimistic attitude about the future—negative thinking about the past.
- The inability to respond with apparent pleasure to praise or reward.
- Tearfulness or crying.
- Change in weight—poor appetite with weight loss or weight gain.

Depression (Cont’d)

- Recurrent thoughts of death or suicide.
- Decreased sex drive.
- Anxiety.

What is CPR?

- **C**urrent Suicide Plan.
- **P**rior Suicidal Attempt.
- **R**esources.

Current Suicide Plan

- The presence of a suicide plan and any details of that plan.
- Example 1: “I have thought about it, but I don’t know how I’d do it.”
- Example 2: “I have a gun under my bed, and a bullet that I’m saving. Yep, next Tuesday at noon, my problems will all be over.”

Prior Suicidal Behavior

- History of self-injury, including “modeling” by family and others.
- Has there been an attempt by the person, or an attempt by a family member.

Resources

- Absence of physical and emotional resources which the person feels are helping, caring or supportive, including: other persons (family, friends, caregivers); groups and organizations to which the person belongs; economic assets, etc.

Suicide First Aid

- None of us is a professional, but we can all administer first aid.
- Engage-the person in serious conversation.
- Identify-if the person has thoughts of suicide. (CPR)
- Inquire-about the reasons for and against suicide.
- Estimate-the risk of suicide.
- Contract-to prevent the immediate risk of suicide.
- Implement-the plans in the contract.
- REAPPLY AS NECESASARY